PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 253

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-3-30 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 30. (a) As used in this section, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-14.2-1.

(b) As used in this section, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

(c) As used in this section, "mandated benefit" means certain health coverage or an offering of certain health coverage that is required under:

(1) an accident and sickness insurance policy; or

(2) a contract with a health maintenance organization.

(d) As used in this section, "mandated benefit proposal" means a bill or resolution pending before the general assembly that, if enacted, would require certain health coverage or an offering of certain health coverage under:

(1) an accident and sickness insurance policy; or

(2) a contract with a health maintenance organization.

(e) The commissioner shall establish a task force to review mandated benefits and mandated benefit proposals.

(f) The task force must consist of ~~nine (9)~~ **ten (10)** members appointed by the governor as follows:

(1) Two (2) members representing the insurance industry.

(2) Two (2) members representing consumers.

(3) Two (2) members representing health care providers.

(4) Two (2) members representing the business sector.

(5) One (1) member who is an independent actuary.

~~(5)~~ **(6)** The commissioner or the commissioner's designee.

A registered lobbyist may not serve as a member of the task force.

~~(g) Members of the task force shall serve on a voluntary basis without reimbursement.~~

(g) Each member of the task force who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(h) Each member of the task force who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(i) Each member of the task force shall attend at least fifty percent (50%) of scheduled meetings. A member who does not comply with this subsection is subject to replacement by the governor.

~~(h)~~ **(j)** The department shall provide administrative **and actuarial** support for the functions of the task force**, including the use of the services of the department's actuary as necessary for the completion of the duties of the task force under this chapter.**

~~(i)~~ **(k) Upon the:**

(1) request of the legislative services agency on behalf of a member of the general assembly; or

(2) determination of the task force;

the task force shall ~~review mandated benefits and~~ **assess the social, medical, and financial impacts of at least one (1)** mandated benefit ~~proposals as determined by the members of~~ **or one (1) mandated benefit proposal each year.**

(l) In assessing a mandated benefit or mandated benefit proposal, and to the extent that information is available, the task force shall consider:

(1) social impacts, including:

(A) the extent to which the service that is the subject of the mandated benefit or mandated benefit proposal is generally used by a significant part of the population;

(B) the extent to which the health coverage is already generally available;

(C) if the health coverage is not generally available, the extent to which the lack of health coverage results in unreasonable financial hardship;

(D) the level of public demand for the service that is the subject of the mandated benefit or mandated benefit proposal;

(E) the level of public demand for the health coverage; and

(F) the extent to which the service that is the subject of the mandated benefit or mandated benefit proposal is covered under self-funded health coverage provided by Indiana employers that employ at least five hundred (500) employees;

(2) medical impacts, including the extent to which the service that is the subject of the mandated benefit or mandated benefit proposal is generally:

(A) recognized by the medical community as effective in patient treatment;

(B) demonstrated by a review of scientific and peer review literature to be recognized by the medical community; and

(C) available and used by treating physicians; and

(3) financial impacts, including the:

(A) extent to which the health coverage will increase or decrease the cost of the service that is the subject of the mandated benefit or mandated benefit proposal;

(B) extent to which the health coverage will increase the appropriate use of the service that is the subject of the mandated benefit or mandated benefit proposal;

(C) extent to which the service that is the subject of the mandated benefit or mandated benefit proposal will be a substitute for a more expensive service;

(D) extent to which the health coverage will increase or decrease the:

(i) administrative expenses of accident and sickness insurers and health maintenance organizations; and

(ii) premium and administrative expenses of individuals covered under accident and sickness insurance policies and health maintenance organization contracts;

(E) impact of the health coverage on the total cost of health care in Indiana, including any potential cost savings that may be realized through the mandated benefit or mandated benefit proposal;

(F) impact of all mandated benefits on the ability of employers to purchase health coverage that meets employee needs;

(G) extent to which the financial impact of all mandated benefits, including the mandated benefit or mandated benefit proposal under consideration, will affect employee wages and compensation; and

(H) extent to which the financial impact of all mandated benefits, including the mandated benefit or mandated benefit proposal under consideration, will affect hiring practices of Indiana employers.

(m) The task force shall annually determine the full cost of all existing mandated benefits in Indiana as a percentage of:

(1) Indiana's average annual wage; and

(2) health coverage premiums.

(n) In making the annual determination under subsection (m), the task force shall consider the full cost of existing mandated benefits under:

(1) a typical group and individual:

(A) accident and sickness insurance policy; and

(B) health maintenance organization contract;

in Indiana; and

(2) the state employee health plans provided for in IC 5-10-8-7(b) and IC 5-10-8-7(c).

(o) The task force may contract for professional services as necessary for the completion of the duties of the task force under this chapter.

(p) The task force ~~and~~ **shall** report **the findings of the task force** in an electronic format under IC 5-14-6 to the legislative council not later than ~~December 31~~ **November 1** of each year.

~~(j)~~ **(q)** Any recommendations made by the task force must be approved by at least ~~five (5)~~ **six (6)** members of the task force.

~~(k)~~ **(r)** The department may adopt rules under IC 4-22-2 to implement this section.

~~(l)~~ **(s)** Information that identifies a person and that is obtained by the task force under this section is confidential.

(t) This section expires December 31, 2010.

SECTION 2. IC 27-8-5-2 IS AMENDED TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2005]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age, which shall not exceed nineteen (19) years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to

a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded or mentally or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the

insured.

SECTION 3. IC 27-8-5-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the enrollment date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the enrollment date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the enrollment date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that

must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, **in electronic or paper form,** setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid in accordance with IC 27-8-5.7; and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family

status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the

child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or mentally or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection (c)(8); and

(2) request the certificate in paper form.

SECTION 4. IC 27-8-5.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. (a) The commissioner shall prescribe by rule, after consultation with providers of health care or treatment, accident and sickness insurers, hospital, medical, and dental service corporations and other prepayment organizations, such accident and sickness insurance claim forms as the commissioner determines will provide for uniformity and simplicity in insurance reporting. The forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to

the providing of care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident or sickness insurance policy or a hospital, medical, or dental service contract.

(b) An accident and sickness insurer may not refuse to accept a claim submitted on duly promulgated uniform claim forms. However, an insurer may accept claims submitted on any other form.

(c) Accident and sickness insurer explanation of benefits paid statements or claims summary statements sent to an insured by the accident and sickness insurer **may be sent in electronic or paper form and** shall be in a format and written in a manner that promotes understanding by the insured by setting forth:

(1) the total dollar amount submitted to the insurer for payment;

(2) any reduction in the amount paid due to the application of any co-payment or deductible, along with an explanation of the amount of the co-payment or deductible applied under the insured's policy;

(3) any reduction in the amount paid due to the application of any other policy limitation or exclusion as set forth in the insured's policy along with an explanation thereof;

(4) the total dollar amount paid; and

(5) the total dollar amount remaining unpaid.

In addition, the explanation shall clearly set forth a toll free number that the insured may call to obtain additional information about any of the items contained in the explanation of benefits paid or claims summary statement.

(d) The commissioner may issue an order under IC 27-1-3-19(a) directing an accident and sickness insurer to comply with subsection (c).

(e) An accident and sickness insurer does not violate subsection (c) by using a document that the accident and sickness insurer has been required to use by the federal government or the state.

(f) An accident and sickness insurer shall:

(1) inform an insured that the insured may request that the statements described in subsection (c) be sent in paper form; and

(2) send the statements in paper form upon the request of the insured.

SECTION 5. IC 27-8-11-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 8. (a) An insurer may provide to an insured in electronic or paper form a directory of providers with which the insurer has entered into an agreement under section 3 of this**

chapter.

(b) An insurer that provides a directory described in subsection (a) shall:

(1) inform the insured that the insured may request the directory in paper form; and

(2) provide the directory in paper form upon the request of the insured.

SECTION 6. IC 27-13-7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5. **(a)** A subscriber under a group contract must receive an evidence of coverage from:

(1) the group contract holder; or

(2) the health maintenance organization.

(b) A group contract holder or health maintenance organization may provide the evidence of coverage required under subsection (a) in electronic or paper form. The group contract holder or health maintenance organization shall provide the evidence of coverage in paper form upon the request of the subscriber.

(c) A health maintenance organization shall include in the health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:

(1) obtain an evidence of coverage; and

(2) request the evidence of coverage in paper form.

SECTION 7. IC 27-13-9-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. **(a)** Upon:

(1) the enrollment; and

(2) each reenrollment;

of a subscriber, a health maintenance organization must provide to the subscriber **in electronic or paper form** a list of providers who provide health care services through the health maintenance organization. The health maintenance organization must also provide the list of providers **in electronic or paper form** to a potential enrollee upon request.

(b) A health maintenance organization shall:

(1) inform a subscriber or potential enrollee that the subscriber or potential enrollee may request a list described in subsection (a) in paper form; and

(2) provide the list in paper form upon the request of the subscriber or potential enrollee.

SECTION 8. IC 27-13-34-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) Every subscriber of a limited service health maintenance organization shall be issued an evidence of coverage **in electronic or paper form,** which must contain a clear and complete statement of the following:

(1) The limited health services to which each enrollee is entitled.

(2) Any limitation of the services, kinds of services, or benefits to be provided.

(3) Any exclusions, including any copayment or other charges.

(4) Where and in what manner information is available as to where and how services may be obtained.

(5) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document **in electronic or paper form.**

(c) A limited service health maintenance organization shall issue the evidence of coverage described in subsection (a) and an amendment described in subsection (b) in paper form upon the request of the subscriber.

(d) A limited service health maintenance organization shall include in the limited service health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:

(1) obtain an evidence of coverage; and

(2) request the evidence of coverage in paper form.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Approved: _____

Governor of the State of Indiana